SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*42644*
Company Tracking Number:	*A69931NMMMST01 01A*		
TOI:	*MS05G Group Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05G.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Inquiry - Thoughtform enrollment application/A69931NMMMST01 01A*		

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: UHLC-126186071	State: ArkansasLH
TOI: MS05G Group Medicare Supplement - Standard Plans	SERFF Status: Closed	State Tr Num: 42644
Sub-TOI: MS05G.001 Plan A	Co Tr Num: A69931NMMMST01 01A	State Status: Filed-Closed
Filing Type: Form	Co Status:	Reviewer(s): Stephanie Fowler
	Author: Tammy Frederick	Disposition Date: 07/14/2009
	Date Submitted: 06/11/2009	Disposition Status: Filed-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Inquiry - Thoughtform enrollment application	Status of Filing in Domicile: Not Filed
Project Number: A69931NMMMST01 01A	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 07/14/2009	Explanation for Other Group Market Type:
	State Status Changed: 07/14/2009
Deemer Date:	Corresponding Filing Tracking Number: A69931NMMMST01 01A

Filing Description:

We enclose for your information and review, proof copies of advertising material for use in connection with the AARP group health insurance program. The enclosed enrollment application is new and does not replace any material previously submitted to the Department.

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The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "…not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found on the advertising material submitted on 6/11/2009 under SERFF Filing No: UHLC-126186021. This enrollment application will be used with those materials.

The attached list of enclosures indicates the contents of each package including the form number, and title of each item.

We trust the enclosed forms are in order and look forward to your prompt acknowledgment of this filing. If you have any further questions you can contact me at 215-902-8444. If you prefer, you may also send a facsimile to me at Fax: 215-902-8813 or send an email to me at Susan_J_Cipollo@uhc.com.

A69931NMMMST01 01A-ENROLLMENT APPLICATION

PCG2 – Your Plan Choice Guide*
POV1 – Overview of Available Plans*
BT 1 through BT 12 – Benefit Tables*
RD1 - Rules and Disclosures*

*THESE LEGAL COMPONENTS WERE SUBMITTED TO THE DEPARTMENT ON 5/21/2009.

Company and Contact

Filing Contact Information

Susan Cipollo, Director
680 Blair Mill Rd.
Horsham, PA 19044
Susan_J_Cipollo@uhc.com
(215) 902-8444 [Phone]
(215) 902-8813[FAX]

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Life and Health

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
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PO Box 150450
Hartford, CT 06115-0450
(860) 702-5000 ext. [Phone]

Group Name:
FEIN Number: 36-2739571

State ID Number:

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*42644*
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Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	per enrollment form. 1 form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$20.00	06/11/2009	28506262

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
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Project Name/Number:	*Inquiry - Thoughtform enrollment application/A69931NMMMST01 01A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Stephanie Fowler	07/14/2009	07/14/2009

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
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Disposition

Disposition Date: 07/14/2009
Implementation Date:
Status: Filed-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*42644*
Company Tracking Number:	*A69931NMMMST01 01A*		
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	Enrollment Application	Filed	Yes

SERFF Tracking Number:	*UHLC-126186071*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*42644*
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Form Schedule

Lead Form Number: A69931NMMMST01 01A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	A69931NMMMST01 01A	Application/ Enrollment	Enrollment Application Form	Initial			A69931NMMMST01 01A.pdf

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Enrollment Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Note: Plans and rates in this kit are good only for this address.

Please reply by
xxxxxx
for coverage to be effective on
xxxxxx

AARP membership number
xxxxxx

Have you changed your name or address?
○ Y ○ N

If **YES**, please write your new name and/or address below:

Name

Street Number/Name

City State Zip Code

Instructions

- Complete all the sections of this form (Sections 1 to 4) and sign in the area highlighted in yellow.
- Print clearly. Use CAPITAL letters.
- Fill in the circles with black or blue ink. Not pencil.

  Example: ○ Y ● N
- Mail the completed form *and* all necessary payments, if applicable, in the enclosed envelope. If your envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.
- You can also fax this form to 1-888-836-3985 and you will be billed later.
- Questions? Please call 1-800-620-9037 (TTY: 1-800-232-7773) to talk to a representative.
- If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

1 Personal Information

Phone
Area Code and Phone Number

Birthdate M M D D Y Y Y Y

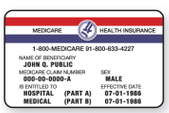
Gender ○ M ○ F

E-mail address (optional)
E-mail may be used to communicate with you about your account and product offers. Please write all necessary periods (.) and symbols (@) in their own space.

Complete ONLY if you are enrolled in Medicare.

Name on Card (First name/Middle initial/Last name)

Medicare Claim number



Note: This information is on your Medicare card. If you do not have a card, leave these items blank.

Hospital (Part A) Effective Date M M 0 1 Y Y Y Y

Medical (Part B) Effective Date M M 0 1 Y Y Y Y

Are both Medicare Parts A and B coverage active?
○ Y ○ N

Barcode
1.75" x .75"

XXXXXXXXXX XX/XX/XX

Continued on next page ▶

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

2 Select plan and payment information

What plan have you selected?

○ A ○ B ○ C ○ D ○ E ○ F ○ G ○ H ○ I ○ J ○ K ○ L

You are eligible to enroll if you are an AARP member, age 65 or older, enrolled in Medicare Parts A and B, and not duplicating Medicare supplement coverage. You may enroll using this form only if, within the last 6 months you turned age 65 or first enrolled in Medicare Part B at age 65 or older.

Please refer to the enclosed rate page for the monthly cost of the plan you have selected. You will need to submit your first month's payment with this enrollment form.

Please make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured through UnitedHealthcare Insurance Company, send no money now. You will receive updated payment instructions later.

Once your enrollment form is processed, you'll be notified of your acceptance, rate, and insurance start date. You will receive a Certificate of Insurance confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below.

Requested Effective Date

		0	1				
M	M	D	D	Y	Y	Y	Y

3 Past and current coverage information

For your protection, you are required to answer all the questions below (3A through 3L) and sign where indicated in the yellow space.

Please answer all questions to the best of your knowledge.

You do not need more than one Medicare supplement insurance policy.

You may want to evaluate your existing health coverage and decide if you need multiple coverage.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Continued on next page ▶

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3 Past and current coverage information, continued

3A. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

○ Y ○ N

Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer **No** to this question.

If you answered YES to 3A, please continue to **3B**.
If No, skip to question **3D**.

3B. Will Medicaid pay your premiums for this Medicare supplement policy?

○ Y ○ N

3C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

○ Y ○ N

3D. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Y ○ N

If YES, fill in your start and end dates and continue to question **3E**. If you are still covered under this plan, leave the end date blank. **If No,** skip to question **3H**.

Start Date M M D D Y Y Y Y (0 1)

End Date M M D D Y Y Y Y (0 1)

3E. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

○ Y ○ N

3F. Was this your first time in this type of Medicare plan?

○ Y ○ N

3G. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

○ Y ○ N

3H. Do you have another Medicare supplement policy in force?

○ Y ○ N

If you answered YES to 3H, please continue.
If No, skip to question **3J**.

3I. If YES, do you intend to replace your current Medicare supplement policy with this policy?

○ Y ○ N

3J. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

○ Y ○ N

If YES, please list with what company and what type of policy in the space provided below. Then continue to question **3K**. **If No,** please continue to **Section 4**.

Company Name

Policy Type

Continued on next page ▶

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3 Past and current coverage information, continued

3K. What are your dates of coverage under the policy you listed in **3J**? Leave the end date blank if you are still covered under the other policy.

Start Date M M D D Y Y Y Y

End Date M M D D Y Y Y Y

3L. Are you replacing this health insurance?

○ Y ○ N

4 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

My signature indicates that I have read and understand the contents of this enrollment form.

I declare that the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this enrollment form becomes a part of the insurance contract and that if the answers are incorrect and untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand that the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

I have read all information and have answered all questions to the best of my ability.

Your signature (required) ▶ _____

Today's Date (required) M M D D Y Y Y Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

ENROLLMENT FORM CHECKLIST

Did you remember to…

- ✔ Complete this enrollment form in black or blue INK?
- ✔ Fill in all information in all sections?
- ✔ Include termination notice from previous insurance coverage (if applicable)?
- ✔ Enclose your first month's insurance payment?
- ✔ Complete the AARP membership form and enclose your dues (if not already a member)?

Thank you!

Questions? Call 1-800-620-9037